Massachusetts Department of Public Health

Office of Emergency Medical Services

Part A: Ambulance Service License Application

1) Service Number	2) Service Expiration Date	3) Is this application _____Initial _____Renewal _____Modification Modification of License to: ____Advanced ____Paramedic ____ Critical Care Transport
| | |		

4) SERVICE INFORMATION

Name			
Address			P.O. Box
City	State		Zip
Business Phone Number ( )		Fax Number ( )	
Manager Name	Contact Person		E-mail address

7) LICENSEE INFORMATION

Name			
Address			
City	State		Zip
Business Phone Number	( )	24 Hour Access Number, Non 911	( )
E-mail address		24 Hour Access Fax Number	( )

8) PARENT or ASSOCIATED COMPANIES OF OWNER

Name			
Address			
City	State		Zip
9) Service Ownership Type?	Sole Proprietor Government	Partnership Corporation LLC	Limited Partnership Other:

10) Is this service hold other valid licenses in the Commonwealth of Massachusetts? ☐ YES ☐ NO

11) Level of License applying ☐ BLS ☐ Advanced ☐ Paramedic ☐ Critical Care

12) With which hospital(s) do you have an affiliation agreement or memorandum of understanding or medication exchange?

Hospital Name	ALS	Glucose Monitoring	Alb/Narcan	EPI/Aspirin

13) Total number of vehicles Class I	Class II	Class IV	Class V	EFR

14) Total number of EMS personnel **EMTs:** Basic: Intermediate: Advanced: Paramedic:	Services uses Paramedic/ Basic Minimum Staffing **YES** **NO**

15) Does the ambulance service respond ONLY to calls from a unique population? ☐ YES ☐ NO

If yes, identify population(s): _____

16) Indicate the number of runs performed by this service in the last calendar/fiscal year	___/___/_____ Date From	___/___/_____ Date To	**Yes** / **No** Are numbers estimated?	Total Number of Responses (incl cxl,refusal):

Emergency Transports BLS:	Emergency Transports ALS:	Routine Transports BLS:	Routine Transports ALS :	Total Transports:

17) Do you currently have any Waivers?

Check	Waiver Type	Extension Requested
	Vehicle Waivers	**YES** **NO**
	Service Operation Waivers	**YES** **NO**
	Special Project Waiver	**YES** **NO**
	Other	**YES** **NO**

OEMS use only	Fee Received	Amount

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STATEMENT OF NON-DISCRIMINATION

Pursuant to 105 CMR 170.335 of the Emergency Medical Services System Regulations, Regulating Ambulances and Ambulance Services, "no person shall discriminate on the grounds of race, color, religion, national origin, sex, sexual orientation, age, ancestry or disability in any aspect of its provision of ambulance or EMS first response service or in employment practices. This section requires compliance with M.G.L. c. 151B, as amended, which is a statute prohibiting unlawful discrimination."

This ambulance service is and will continue to be in conformance with these requirements.

TAX CERTIFICATION STATEMENT

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

This license will not be issued unless this certification clause is signed by the applicant.

Your tax identification number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or are delinquent WILL BE SUBJECT TO LICENSE SUSPENSION OR REVOCATION. This request is made under the authority of M.G.L. c. 62C s. 49A.

18) License social security or federal identification number: ☐

19) Does this service have any outstanding assessments levied by the Commonwealth of Massachusetts? ☐ YES ☐ NO

I understand that additional information may be required by the Massachusetts Department of Public Health to complete the application process, and agree to provide such information as requested. I, the undersigned, attest that I am duly authorized to complete and sign this application, that I have read this application in its entirety and that the information contained herein is complete, accurate and true. Signed under the pains and penalties of perjury.

Authorized Signature _____ Date _____

Print Name _____ Date _____

FEE INFORMATION

Fee must accompany application or a letter of explanation must be submitted.
Applications will not be submitted to Public Health Council until fee has been received.

FEES ARE AS FOLLOWS:
BLS only: $400 ambulance service license, plus $200 per vehicle for Certificates of Inspection, OR
ALS (and BLS): $600 ambulance service license, plus $200 per vehicle for Certificates of Inspection.
ALS Upgrade: $600 ambulance service license upgrade (no Certificate of Inspection fee required if the upgrade is not at time of relicensure)
Make check(s) payable to Commonwealth of Massachusetts.

Return completed application packet, fee and proof of insurance to:

Office of Emergency Medical Services
99 Chauncy Street, 11th Floor
Boston, MA 02111